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4 July 2009
1859-2009 Celebrating 150 years in pharmacy

American idol

What UK pharmacy can learn from the USA page 18

PLUS

IMPORTANT REMINDER

New Lilly UK Medicines Supply and Distribution Service effective from 6th July 2009

From Monday 6th July 2009, PHOENIX Healthcare Distribution Limited and AAH Pharmaceuticals Limited will be the sole Logistics Service Providers for Eli Lilly and Company Limited, distributing our medicines to UK pharmacies and dispensing doctors.

Ensuring continuity of supply

We have comprehensively prepared for a successful transition to the new distribution arrangements on 6th July. This includes ensuring that there is coverage throughout the UK to provide an effective service for you, pre stocking of the depots throughout the UK ready for the switch and working with the other UK wholesalers to ensure a smooth transition.

What do I need to do if I already have an active trading account with PHOENIX Healthcare Distribution Limited or AAH Pharmaceuticals Limited?

Nothing – your order processing, medicine distribution, invoicing and cash collection will remain the same. The only difference will be that the purchase of Eli Lilly and Company Limited medicines will be subject to the Terms and Conditions and Discount structure of Eli Lilly and Company Limited as set out in recent correspondence to you or please visit www.lilly.co.uk.

What do I need to do if I DO NOT have an active trading account with PHOENIX Healthcare Distribution Limited or AAH Pharmaceuticals Limited?

If you do not have an account with either Logistics Service Provider then you will need to set up an account with one of them for the supply of Eli Lilly and Company Limited medicines before the changes are implemented on Monday 6th July 2009. Contact details for both our Logistics Service Providers can be found below. Your account will be subject to the Terms and Conditions and Discount structure of Eli Lilly and Company Limited as set out in recent correspondence to you or please visit www.lilly.co.uk.

If you have any questions, please contact our customer services team on 01256 315 999.

PHOENIX Healthcare Distribution Limited
A company of the PHOENIX group

Contact details for PHOENIX Healthcare Distribution are:

T: 0844 892 2130
E: lillyenquiries@phoenixmedical.co.uk

PHOENIX CEO, Paul Smith said:

"PHOENIX has the professionalism and capabilities required to service the market within a two wholesaler model. Our existing customers already enjoy these benefits and PHOENIX is committed to providing the same excellent and efficient service for its new agency customers.

Our commitment is underlined through our continued investment in the network and with the addition of our new depot in Swanley, PHOENIX is in the position of being able to deliver products and services throughout the Four Nations."

AAH

Contact details for AAH Pharmaceuticals Limited are:

T: 02476 625 432
E: newaccountenquiries@aah.co.uk

AAH Group Managing Director, Mark James said:

"AAH has worked closely with Lilly UK to meet their requirement to offer a model which will ensure coverage throughout the UK, deliver high levels of service and retain a robust supply chain. We believe that the solution that has been developed will offer all AAH customers the best possible service on Lilly UK products and provide access to the full range of products and services that are proudly offered by AAH Pharmaceuticals Ltd."

Somatropin (Human Growth Hormone) "Humatrope" supply

Please note that the sale and distribution arrangements for Somatropin Human Growth Hormone (Humatrope®) products will also change. This product will only be available from Healthcare at Home from 6th July 2009. If you do not already have an account with Healthcare at Home please call 0870 600 1545 to set this up. If you have used Healthcare at Home in the past they will have your account details and you will be able to place your orders by fax (0870 421 1317) as required.

Lilly
Answers That Matter.

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PPA ABC

TABPI Awards 2008
Winner for news coverage

> OUR INABILITY TO NARROW THE GAP BETWEEN THE RICH AND POOR REMAINS A CONTINUING FRUSTRATION

If you are lucky enough to live in a wealthy area, have access to good education and a rewarding job, then you really have struck gold.

Not only do you have the aforementioned fortune, you are going to have more time to enjoy it as you will probably live on average seven to eight years longer than those in more deprived areas.

Our special report into health inequalities (p8) highlights the disparities that exist between the haves and have nots.

Differences in life expectancy, infant mortality and levels of chronic disease may be shocking to read but they are not new. Our inability to narrow the gap between the rich and poor, however, remains a continuing frustration despite the plethora of reports and studies on the issue.

And with the latest government report on finding a way to make health outcomes between social classes more equitable still some months away (p8), surely there must be 'easy wins' that could be implemented now?

In today's risk averse climate, however, those with the power to make things happen are unlikely to invest in services without the evidence to support the funding. And this just creates a Catch 22 situation, for if you don't invest, what chance is there of getting the evidence to support wider roll out of these much needed services?

We've argued this before, but there are 12,500 highly accessible health access points located across the UK, covering high streets to rural areas and shopping centres to deprived housing estates.

Ninety nine per cent of the population can access health services from a pharmacy without an appointment within minutes of their home. And for something as straightforward as smoking cessation, for example, the evidence is clear. Community pharmacists and their staff can help people to quit smoking and they can do it well and do it cost effectively.

With over 100,000 smoking related deaths in the UK every year, you have to wonder why there is no nationally agreed and funded service commissioned from a network visited by six million people every day. The knock-on benefits for the NHS would be both immediate and significant.

Our USA special (p18) highlights the variety of public health roles that pharmacists can successfully deliver. And if we're really going to close the health gaps that exist, then better use of the pharmacy network by local commissioners is a must.

Gary Paragpuri, Editor

Big pharma comes out fighting as NPA takes supply deals to OFT

ABPI accuses pharmacy chief of having overactive imagination after distribution scheme attack

The war of words

ON DTP SCHEMES
John Turk: DTP schemes are a "disaster waiting to happen".
David Fisher: DTP is not the reason for the current pressure on the supply chain.

ON SUPPLY CHAIN PROBLEMS
John Turk: Manufacturers thinking they can control the supply chain is "complete and utter bollocks".
David Fisher: His imagination, it seems, is as colourful as the language he uses.
John Turk: The view I expressed was a reflection of the growing frustration our members feel about their ability to provide a responsive service for patients.

ON SOLUTIONS
David Fisher: The ABPI is firmly focused on finding a long-term solution to the problem.
John Turk: My view is that we need to sit round a table and get this sorted.

ON THE WAR OF WORDS
David Fisher: There is little value in a war of words.
John Turk: I do concur with Mr Fisher's point that we do not want a war of words.

Zoe Smeaton
zsmeaton@cmpmedica.com

Drugs firms have hit back after the head of the NPA branded manufacturer supply deals "complete and utter bollocks" and blamed them for stock shortages.

John Turk's imagination was "as colourful as the language he uses", the Association of the British Pharmaceutical Industry (ABPI) said. Pharmacists exporting medicines were the real cause of supply problems, the ABPI reiterated.

But Mr Turk defended his comments and the NPA upped the ante by revealing it had called for an Office of Fair Trading (OFT) investigation into manufacturer supply deals. The move is likely to further inflame relations with big pharma, which have been tested amid continuing branded drugs shortages this year.

ABPI commercial director David Fisher this week wrote to C+D saying that pressure on the supply chain was being caused by the export of medicines out of the UK by a minority of pharmacists.

He said independent analysis showed manufacturers were supplying medicines at a higher level than required to meet UK demand. Shortages were affecting products from a wide range of manufacturers, irrespective of their distribution arrangements, he said.

Mr Fisher said there was little value in a war of words and added: "The ABPI is firmly focused on finding a long-term solution to the problem."

Out-of-stocks: the situation is so bad that the OFT must investigate, says the NPA

Mr Turk agreed that he did not want a war of words, but said NPA members' views of the reasons for stock shortages were not "imaginary". He said members had told the NPA they were struggling to get hold of items that had quota and/or restricted distribution controls.

The association has made initial contact with the OFT after gathering evidence of stock problems, NPA chairman Ian Facer told C+D. An OFT report in 2007 gave the all-clear to manufacturer supply deals, but the competition watchdog added that future arrangements could lead to unfair competition.

Mr Facer said: "We believe the grounds for intervention by the OFT have been reached."

An OFT spokesperson said any complaints made were confidential, but would be taken very seriously.

PSNC chief executive Sue Sharpe said the committee had continued to consider whether an approach to the OFT would be helpful in the light of their previous inquiries. These had found no evidence that the distribution schemes affected service standards.

Ms Sharpe added: "We will look forward to seeing the result of the NPA's reference to the OFT."

Pfizer said its distribution arrangement continued to maintain "excellent service levels to all its customers" and said it was confident they were in full compliance with EU and UK competition law.

Read the ABPI and NPA letters in full
www.chemistanddruggist.co.uk

John Stillwell/PA Wire

Gordon Brown meets patients at the Barkantine Health Centre this week

PM visits polyclinic pharmacy

Prime Minister's questions took a twist this week as Gordon Brown quizzed London pharmacist Devshi Chandegra about life in a polyclinic.

The PM met Mr Chandegra during a trip to the new £12 million Barkantine Health Centre on the Isle of Dogs. Mr Chandegra told C+D: "He spent about five minutes just asking me what the views of the patients were of our set up. I told him they were positive."

Had he stayed a little longer Mr Brown might have faced the kind of difficult questions he's grown used to at Westminster recently. Mr Chandegra added: "If I had got the time I would have told him how we're spending a lot of time chasing the industry for stocks. We would request that the government help us."

Mr Chandegra's Barkantine Pharmacy moved into the polyclinic under a minor relocation. **MG**

July is Heart Health Month
Check out our definitive guide on page 15

Public health is number one priority for Tories

Prevention, not treatment, will be main priority, says MP

Jennifer Richardson
jrichardson@cmpmedica.com

A Conservative government would make public health its main priority, the shadow pharmacy minister has said.

If they win next year's general election, the Tories would rename the Department of Health as the Department of Public Health, ring-fence public health budgets and hand all other NHS expenditure to an independent, autonomous body, Mark Simmonds MP told an NPA summit this week.

In further efforts to improve public health, the Conservatives plan to appoint local directors of public health, who will be jointly accountable to PCTs and local authorities. They would also enhance the role of the chief medical officer.

The Conservative Party was expected to unveil a commission on public health as C+D went to press.

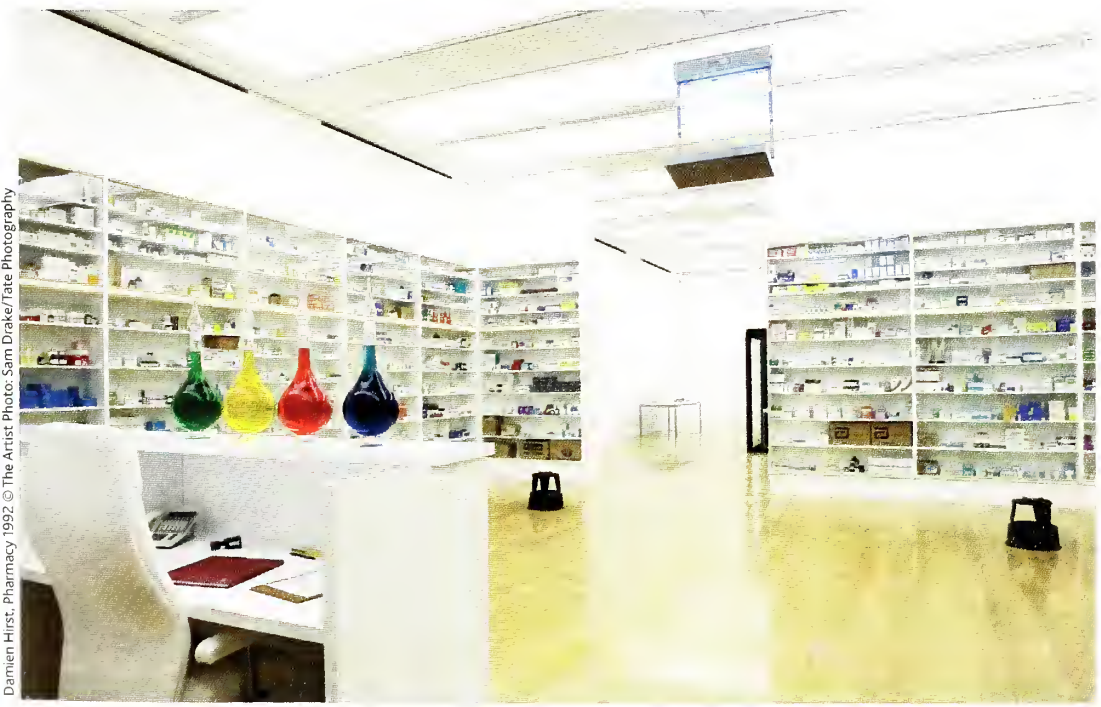
The Party had decided to focus on public health because the current situation was "terrible" and "deteriorating by the day", Mr Simmonds said. He told C+D: "If we're going to significantly affect the health of the population we're going to have to have a much greater focus on prevention rather than treatment."

Mark Simmonds: the DH will be renamed the Department of Public Health

The NHS was the Tories' "number one priority", he pledged. "We're going to continue to increase the amount of expenditure going into the health service."

The Party wanted to introduce a pharmacy QOF (quality and outcomes framework) aligned with the GP QOF to incentivise collaboration, Mr Simmonds added.

It was "very supportive" of last year's pharmacy white paper, though felt pharmacy remained "undervalued".



Damien Hirst, Pharmacy 1992 © The Artist Photo: Sam Drake/Tate Photography

Damien Hirst's Pharmacy exhibition is now on show in London at the Tate Britain. In the room installation, Mr Hirst brings the apparatus of pharmacy into the art gallery. Speaking about the work, Mr Hirst has said previously: "I noticed that [people] were believing in medicine in exactly the same way that I wanted them to believe in art." Pharmacy is on show as part of the BP Exhibition: Classified. Entry is free, it runs from June 22 to August 23 and is open daily from 10am to 5.50pm.

Amlodipine recall

Greystone has recalled several batches of 5mg and 10mg amlodipine tablets over quality assurance fears. In a class 2 medicines recall, the MHRA said an inspection of Greystone's contract manufacturer had found "serious" deficiencies in Good Manufacturing Practice (GMP). See affected batches at **www.chemistanddruggist.co.uk**

Asthma cost too high

A University of Manchester study has strengthened evidence that the cost of treatment is encouraging asthma patients to skimp on treatments. **www.thepcrj.org** **www.chemistanddruggist.co.uk**

Team pharmacy/GP

The NHS may not be able to make service quality improvements or productivity gains unless GPs and pharmacists can work together effectively, a report from the School of Pharmacy, University of London, has warned. **www.chemistanddruggist.co.uk**

New role for McCreedy

Former NPA chief pharmacist Colette McCreedy, who was made redundant last year, has taken up a new role as specialist in self-medication at the MHRA. Her appointment was welcomed by members of the pharmacy profession and OTC industry.

EMEA drugs advice

EMEA officials have recommended withdrawing dextropropoxyphene-containing medicines across Europe The move is likely to become legally binding in member states. EMEA also told health professionals to ensure imiglucerase and agalsidase beta went to patients most in need after shortages.

Dispensary talk

Which TV soap would you like to see adopt a pharmacy storyline as part of a PR campaign?

Web verdict

Coronation Street 32%

Doctors 14%

EastEnders 30%

Emmerdale 12%

Hollyoaks 12%

Armchair view: It was a close battle between the top two, but in the end Corrie just pipped Enders to the post as pharmacy's most wanted soap storyline.

"EastEnders, because I watch it. I think it would be useful, and people would actually take on board what they saw."
Ravi Patel, locum pharmacist

"I'd say whichever is the most popular... probably Coronation Street. If it was done in the right way with a good actor it could be good."
Michael Maguire, Marton Pharmacy, Middlesborough

Next week's question:
Have your patients been suffering in the summer heatwave? Vote at **www.chemistanddruggist.co.uk**

Pharmacist struck off for child pornography

Stephen Twibill "tarnished profession's honour and dignity"

A Belfast-based pharmacist has been struck off after being found guilty of viewing child pornography.

Stephen Twibill was removed from the register of the Pharmaceutical Society of Northern Ireland (PSNI) at a hearing of the Statutory Committee last month.

Mr Twibill had earlier been convicted by a Northern Irish court of accessing nearly 20,000 unique indecent images of children.

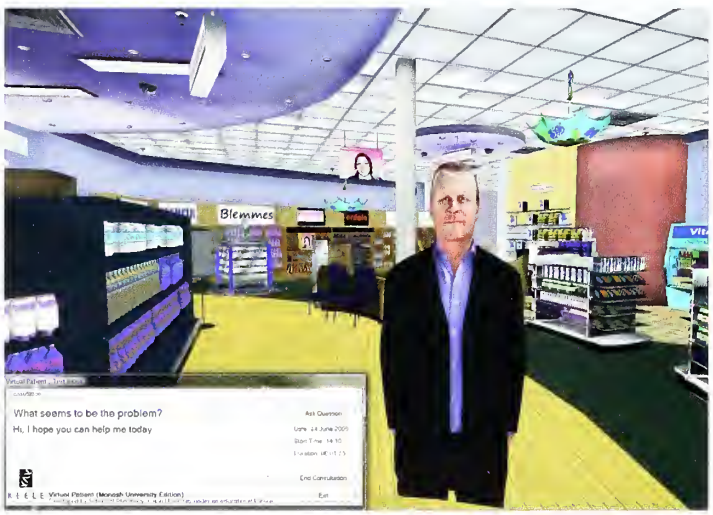
Summing up, Tim Ferris, chairman of the Statutory Committee, said Mr Twibill had severely tarnished his profession's honour and dignity.

He accepted that Mr Twibill had been co-operative with the police after his arrest in October 2007 and that he had paid a heavy price for his actions.

But Mr Ferris pointed out that the public, given the seriousness of his crime, would have grave concerns were his name to remain on the register.

He instructed that Mr Twibill should not attempt to have his name restored to the register for at least 15 years. However, Mr Ferris said that a committee would not necessarily look at a restoration application favourably.

At the court hearing in October 2008 the judge gave Mr Twibill a three-year sentence: one year in custody and two years on parole. A prohibition order was imposed restricting his access to children and vulnerable adults and he was disqualified from working with children for 15 years.



Computer generated patients will help students at Keele University hone their skills in dealing with hayfever this summer. A special programme has been added to help pharmacists combat allergies including allergic rhinitis. The virtual system was launched earlier this year and lets users quiz 3D electronic patients, who then assess students on their performance. The allergic rhinitis programme allows the trainee to go behind the virtual pharmacy counter to read up on allergy treatments – presumably caused by virtual pollen. Users can also quiz patients on their symptoms in a bid to boost their communication and prescribing skills

One-hit kits for addicts aim to reduce spread of hep C

Glasgow pharmacies are providing drug addicts with kits to help reduce the spread of hepatitis C.

NHS Greater Glasgow and Clyde has introduced the One Hit Kit, which includes all the paraphernalia used by addicts along with a disposal bin. More than 60 pharmacies in the health board's area are offering the service, which aims to address the problem of hepatitis C being spread by filters and spoons as well as needles.

There had been a "massive expansion" of community pharmacy's provision of needle exchange in Glasgow, said Carole Hunter, lead pharmacist for the board's addictions partnership.

The One Hit Kit is a national template service that Ms Hunter said other primary care organisations across the UK were considering adding to their needle exchange schemes.

Its introduction in Glasgow, a UK first, has reportedly come under fire from anti-drug campaigners. Ms Hunter said this was "understandable", but that the service had the backing of local police, the Scottish Drugs Forum and family support groups. **JR**

Can drug kits help beat hepatitis C?

jrichardson@cmpmedica.com

Wait goes on for Cat M ruling

Northern Irish pharmacists continue to wait for a landmark legal decision on whether Category M was illegally used to raid purchase profits.

A high court judge was due to make a ruling by the end of June. However, no announcement had been made as C+D went to press.

The judgement follows a courtroom showdown between local contractors and NI health chiefs earlier this month.

Pharmaceutical Contractors Committee chief executive Terry Hannawin told C+D: "We feel the case was well presented and it went well. Our legal team were pleased with how it went."

Northern Ireland's Department of Health declined to comment. **MG**

Views on voting in the Special Resolution Ballot

In 2010, the Society's functions will separate – regulation will transfer to the General Pharmaceutical Council and the Society will form the basis of a new professional leadership body for pharmacy.

The new professional body has pledged to put pharmacists at the heart of everything it does, providing active leadership, a robust voice for pharmacy and the information, advice and support pharmacists need to fulfil their career ambitions.

To pave the way for this transition, changes need to be made to the Society's Royal Charter. Members have contributed to a 12-week consultation about the changes, and the Society's Council is now asking all members to vote 'Yes' to the proposed changes to the Charter.

There needs to be a 'Yes' vote from two-thirds of those voting for the new professional leadership body to come into effect in an appropriate form in 2010.

Without this, all the Privy Council – effectively government – controls will remain in place, along with a 30 strong Council, including 10 lay members.

The Society is urging all members to use their vote in the ballot, which closes on Monday 20 July. Each and every member is entitled to vote, and can do so by post, internet, phone and text message with a unique PIN number.

Here, four pharmacists give their views about why they will be voting 'Yes' to the Charter changes in the ballot.

Graham Phillips
Community Pharmacist

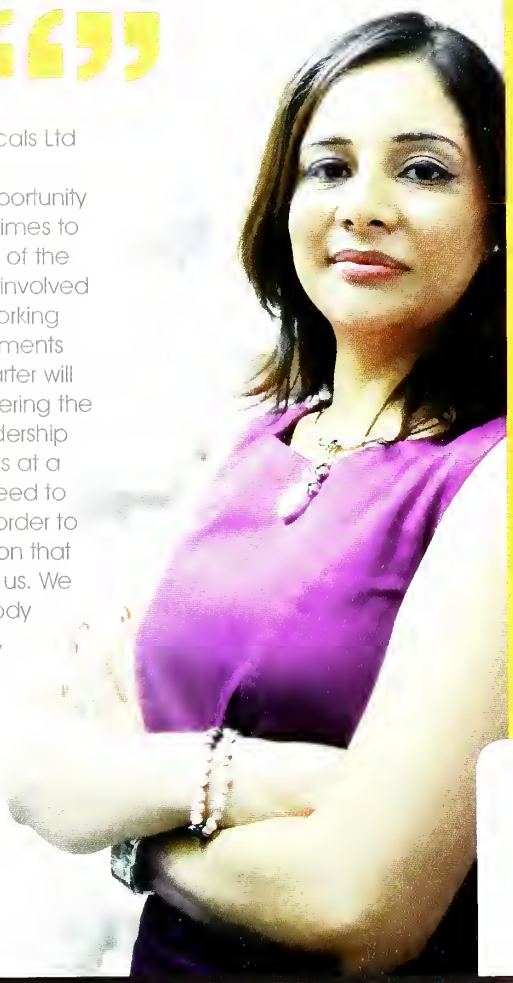
"Should we vote for the Charter changes? Yes. The direction of travel for pharmacy is clear, the government's intention to create a new pharmacy regulator is not in doubt, it would be unthinkable for the regulator, the General Pharmaceutical Council, to be created and for the Charter changes to be rejected leaving us with no professional body, no 'clear strong voice' for pharmacists to challenge and 'tame the regulatory beast' that is the real issue at stake here. **I urge you to vote yes.**"

Lindsey Gilpin
Community locum pharmacist

"I am a locum pharmacist working in the community. I am proud to be a member of a great profession. I want a strong new professional leadership body to represent me to the outside world and support me on an individual basis by organising life-long growth and education as my practice develops into new areas. I simply cannot imagine not being part of an exciting and forward-looking new professional body. **I will be voting 'yes' to make this happen.**"

Marc Donovan
Regional Pharmacy Manager, Boots and Chair of the Welsh Pharmacy Board

"In recent years, we have made great strides towards ensuring pharmacy in Wales makes the most of the opportunities that devolution offers. We have developed structures and ways of working which address the needs of pharmacists in Wales. Making these amendments to the Charter is the next key step in delivering the new professional leadership body. The body will empower pharmacists in Wales to have a greater impact in how the profession develops and ensure that they benefit from services that support their own professional practice. **I'll be voting 'yes' to allow this to happen.**"



Shilpa Gohil
Chief Pharmacist,
Masters Pharmaceuticals Ltd

"We have a great opportunity in these challenging times to help shape the future of the profession by getting involved and committing to working together. The amendments proposed for the Charter will be a key step in delivering the new professional leadership body. The profession is at a crossroads and we need to take the next step in order to create the organisation that we want to represent us. We must give the new body our time and support, so that it can be the best that it can be. **I'll be voting 'yes' in the ballot.**"

Vote now!

Visit **www.pharmacyplb.com**
or call free on **0808 168 5141**

The great health divide

SPECIAL REPORT: HEALTH INEQUALITIES Pharmacy has a crucial role in helping to reduce health inequalities, an NPA summit heard this week. **Jennifer Richardson** reports

"Social injustice is killing people on a grand scale." This may not be a phrase you would equate with 21st century Britain, but it is in fact a major problem we need to tackle, says Dr Jessica Allen, project director of the Marmot review of health inequalities in England.

Last week, this review opened a consultation on its findings to date and, at an NPA-organised summit on health inequalities this week, Dr Allen called on pharmacy to contribute. The summit's audience of movers and shakers from both community pharmacy and the wider NHS heard about the health inequalities challenge the health service faces, and the role the sector can play in tackling it.

The life expectancy of people in the most deprived areas of England is 10 years less than those in the most affluent boroughs

The health inequalities challenge

Despite the current government's commitment to tackling health inequalities having been arguably one of its most consistent health policies, and what Dr Allen views as broad cross-party consensus on this, things have got worse instead of better.

The government's own figures show that over the last 10 years the health inequalities gap between the social classes has widened by 4 per cent among men and 11 per cent among women. And local health profiles unveiled by the Department of Health (DH) this week reveal men living in Kensington and Chelsea can expect to live more than 10 years longer than those living in Blackpool.

That's not to say there haven't been improvements in health overall – in the past decade, average life expectancy has increased by around three years for males and two for females, and infant mortality has fallen to an all-time low of 4.7 infant deaths per 1,000 live births. But the life years lost as a result of the failure to close the persistent chasm between the health of the highest and lowest socio-economic classes is "staggering", says Dr Allen. "The bottom line is this is a matter of social justice, about fairness."

The Marmot review has been charged with developing a strategy to tackle health inequalities once the government's current targets for reducing infant mortality and raising life expectancy become outdated in 2010. And while Dr Allen says there are no silver bullets for the problem, she also believes there are "plenty of win-wins".

> ‘ THE BOTTOM LINE IS THIS IS A MATTER OF SOCIAL JUSTICE, ABOUT FAIRNESS ’

Alex Bax, senior policy advisor to the Mayor of London, likens the health inequalities problem to a man pushing a boulder up a hill, hindered in the goal of improving his health by both the steep gradient and his own lack of strength. In order for the health inequalities problem to be tackled effectively, Mr Bax says, both aspects need to be addressed: the health service must make it easier for people to improve their health and empower them to do so.

The role of community pharmacy

Pharmacy's potential to help reduce health inequalities begins in its position at the heart of local communities and the role of pharmacists as community leaders. The DH's community pharmacy tsar Jonathan Mason argues that pharmacies provide "social cohesion" and support local economies through their impact on other local businesses. Their tendency to employ local residents as staff is also a boost, he adds: "It sends a signal to other employers that it's OK to employ people from the local community."

But pharmacies could do even more to support their local communities, says Mr Bax, who challenges them to take on additional activities. These include 'adopting' a local green space and signposting people to services outside of healthcare that may nonetheless impact on social determinants of health, such as debt counselling. "We know there's a huge role for the advice sector and pharmacies are a place where advice takes place," Mr Bax says.

Pharmacies are already vital providers of signposting to health advice and information, second only to GPs in this role, according to DH research, and with the backing for this to expand further. "I hope that in five years' time pharmacists may be the main source of information and healthy living advice," says Gul Root, public health lead at the DH's pharmacy division. "We want them to be doing it more and more and we will support them in every way we can."

Then there are enhanced services. Many of these match the services needed to reduce health inequalities – including smoking cessation, sexual heath and weight management. Another area they should look to get involved in is alcohol harm reduction, says Mr Mason, who also believes more could be done with medicines use reviews. "We need to look at how we can tap into MURs and provide a wider service," he says.

There are obvious barriers to the utopia of pharmacy contributing its maximum potential to the fight against health inequalities, with IT connectivity, commissioning inconsistencies, funding, premises standards and the need to boost pharmacy's public profile being just some of those raised at the NPA summit.

But there are signs that policy makers and budget holders are waking up to the possibilities. Ms Root says that her division now has DH colleagues from other sectors asking how pharmacy can help deliver their objectives, rather than pharmacy having to go knocking. And after hearing some of the examples of the impact community pharmacy is having when given the opportunity (see The Tower Hamlets story, opposite), Dr Allen says she believes the sector has "huge potential" that the Marmot review could pick up on.

For those NHS managers and commissioners still not convinced, Mr Mason has a simple message: "Choose pharmacy; you know it makes sense."

The Tower Hamlets story

Community pharmacy is part and parcel of Tower Hamlets PCT's attempts to tackle health inequalities in one of the most deprived areas in England, says chief executive **Alwen Williams**

The health inequalities challenge:

- Tower Hamlets is the third most deprived local authority area in England, with one of the highest levels of unemployment at 14 per cent.
- Its population of over 230,000 is fast-growing, highly mobile and young, with 54 per cent under the age of 25.
- In some areas of the borough, over 70 per cent of the population is from a black or ethnic minority community, with 34 per cent of the overall population of Bangladeshi ethnicity.
- Life expectancy in Tower Hamlets is lower than for England over all, by 2.1 years for men and 1.3 for women, with no sign that the gap is closing.
- Three quarters of the life expectancy gap is due to excess deaths from vascular disease, cancer and respiratory disease.

The role of community pharmacy:

- Community pharmacies contributed almost 45 per cent of the total number of smoking quitters in Tower Hamlets in 2008-09. "Seeing pharmacy play such a critical role in this is very encouraging," says Ms Williams.
- In the past year, there has been a 25 per cent increase in the number of consultations carried out by community pharmacists as part of a minor ailments scheme in which all pharmacies and GP surgeries participate.
- Community pharmacists play a central role in access to emergency hormonal contraception, Ms Williams says, contributing to a continuing month on month rise in the number of women accessing the service.
- Ten community pharmacies in the north east of the borough are piloting a type 2 diabetes MUR for six months from the end of July. The specialised MUR will be incorporated into the PCT's primary care investment plan and rolled out to all Tower Hamlets community pharmacies.
- The borough has been split into eight primary care networks with which the PCT will commission, rather than commissioning at a practice level. "Pharmacists will be integral to network approach and delivery," says Ms Williams.
- The PCT expects to publish its Pharmaceutical Needs Assessment (PNA) by September and will incorporate this into its overall strategic needs assessment.

Otex clears ears with syringe kit

In brief

Eli Lilly supply service

Phoenix Healthcare Distribution and AAH Pharmaceuticals will be the sole logistics service providers for Eli Lilly medicines to UK pharmacies from July 6.
Phoenix Healthcare Distribution
Tel: 0844 892 2130
AAH Pharmaceuticals
Tel: 02476 625 432

Bacterial vaginosis on TV

Inverness Medical is backing its Balance Activ Vaginal Gel with a TV campaign on air from the beginning of July until the end of August. Targeting women aged 16 and over, the advertising explains what bacterial vaginosis is and how to treat it. The campaign is part of a £1 million investment in the brand in 2009.
BBI Healthcare
Tel: 0845 677 3349

Catheter replacement

Advance Hydrosoft hydrophilic catheters have been discontinued from the July Drug Tariff. Rochester Medical says that the product can be directly replaced by the Hydrosil catheter, which is the only Drug Tariff silicone hydrophilic catheter for intermittent self-catheterisation. The company will supply a free sample of the Hydrosil catheter in the correct size for your customer. The product is stocked by all major wholesalers.
Rochester Medical
Tel: 0800 032 2755

Dendron is launching an ear wax removal kit designed to make ear wax removal in the home more convenient.

Otex Express Combi pack comprises Otex Express ear drops and a soft bulb ear syringe. Dendron says the syringe is gentle and easy-to-use at home.

After using the ear drops for three to four days to soften and disperse the wax, the syringe can be used to clear the ear canal of any remaining wax or drops. The syringe is filled with warm water which is gently squeezed into the opening of the ear canal, allowing the rinse water to run out into a wash basin.

An independent clinical study has shown that self-treatment with a bulb ear syringe, after initial wax softening using ear drops, can be an effective alternative to professional ear syringing by doctors, says Dendron.

The product launch will be supported by a national press campaign, in addition to TV advertising for the Otex brand throughout 2009.

A range of point-of-sale material includes counter mats, consumer leaflets and shelf edgers. The Combi pack is supplied in a shelf-ready outer case of three units.

Prices and Pip code:
£7.95, 345-3305
Dendron
Tel: 01923 229251

Solpadeine paints the town red

GlaxoSmithKline Consumer Healthcare's Paint the Town Red point-of-sale initiative is being launched this month to drive sales of Solpadeine through pharmacy.

GSK says the campaign is designed to create maximum awareness for the pain relief brand at three focal points: windows, in-store and at the counter.

The brand's flagship variant Solpadeine Plus is featured in eye-catching window display material highlighting the product's soluble format.

Over the summer, GSK will send a series of three competition cards to pharmacies that participate. All correct entries will be included in a prize draw with a chance to win a Brita Aqua Fountain Water Filter Chiller for their pharmacy.

The PoS pack is available through GSK's regional salesforce or direct from www.mypharmassist.co.uk

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Sensodyne is awash with enamel care

GlaxoSmithKline Consumer Healthcare is extending its Sensodyne Pronamel enamel care range with a mouthwash formulated to help protect against acid erosion.

Sensodyne Pronamel Daily Mouthwash has an alcohol-free formulation with a fresh mint taste and is designed to be used as part of a daily mouth care routine.

Acid erosion is expected to become an increasing problem and the mouthwash helps to harden tooth enamel as well as helping to protect against tooth decay, says GSK.

The mouthwash will be supported by its own dedicated national TV campaign as part of GSK's 'experts' promotion, starting in September and running intermittently through to the end of October. GSK is investing £8.7 million in the Sensodyne brand in 2009.

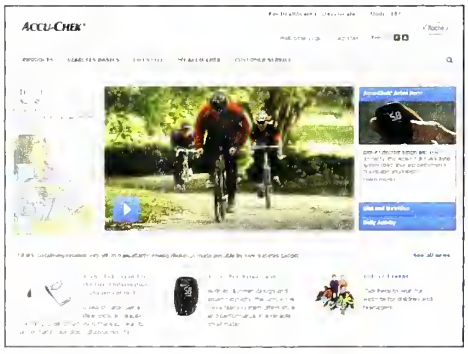
Price and Pip code: £3.59/250ml, 343-8751
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Top marks for Accu-Chek diabetes website

Roche Diagnostics' Accu-Chek website for people with diabetes has been placed among the top rated global websites.

The Webby Award, which is a highly recognised international prize to honour excellence across the internet, placed the Accu-Chek site within the top 15 per cent of over 10,000 website submissions.

People with diabetes and health professionals can find out about the brand's news and products via the website, using interactive tools such as videos and an online ordering facility. The interactive guide to the range is designed to help customers to find the blood glucose system that best fits their lifestyle.



"We have found that customers are looking for more product information from our website as opposed to general diabetes health advice," says Brett Lewis, director of diabetes care at Roche Diagnostics.

Throughout the UK, more than 21,000 patients and healthcare professionals visit the site every month, says the company.

Roche Diagnostics
Tel: 0800 701 000
www.accu-chek.co.uk

The Responsible Pharmacist

For independent pharmacy contractors, the responsible pharmacist regulations will bring new requirements from October 1. Get to grips with them now to ensure you can comply when they come into force.

PART 4 Focus on independent contractors

If you're a pharmacy owner, from October 1 the Responsible Pharmacist (RP) regulations require that for each pharmacy you own, an RP is in charge of the sale and supply of medicines at all times.

As an independent pharmacy owner, unless you have delegated the role, you will be responsible for the appointment of the RP and must ensure they are competent to take on the role.

If your pharmacy premises has been registered for less than three years, you must remember the RP cannot be someone registered in the UK with an equivalent pharmacy qualification awarded in a different EEA country. And you must make it clear to staff who the RP is.

In practice, many independent pharmacists will be the RPs themselves. But if you are away from the pharmacy for more than two hours you will need to appoint another pharmacist as the RP to take over your duties.

To comply with the regulations, a record must be kept of who the RP is at all times and a notice must be displayed on the premises stating the name and registration number of the RP currently in charge of the business. Owners are also responsible for ensuring this record is preserved for at least five years from the date of the last entry in hard copy, or indefinitely if electronic. Failure to do this is a criminal offence. The NPA is developing a paper pharmacy record document for October.

As a pharmacy owner you must also support RPs in complying with their duties, and have systems for them to raise any concerns about the pharmacies. They must be able to access and assess the SOPs and have the freedom to make amendments to these and exercise their professional judgement. They will need to review the SOPs at least every two years. It may also be helpful to supply the SOPs to pharmacists, especially locums, in advance of their shifts so they are familiar with them.

Owners must also take responsibility for any staff employed in their pharmacies, ensuring they are all aware of and can comply with their professional and legal responsibilities and have systems in place to do this.

PART 5 **All you need to know about absence of the responsible pharmacist, in C+D, July 18.**

Five-step guide

1. Read material at www.responsiblepharmacist.com to aid your understanding.
2. Ensure the RP completes the responsible pharmacist record and that this is maintained and preserved.
3. Ensure the RP can display appropriate notices and view and alter SOPs when necessary.
4. Support the RP in complying with the law, but allow them to exercise their professional judgement.
5. Make sure staff are aware of and can comply with their responsibilities.

Don't quite know where the Responsible Pharmacist regulations will leave you? The NPA's head of information Michelle Styles is on hand with the answers. Email haveyoursay@cmpmedica.com and see FAQs at www.responsiblepharmacist.com

The C+D and NPA Responsible Pharmacist Toolkit is supported by McNeil Products Ltd

C+D

McNeil Products Ltd a Johnson & Johnson company — Supporting Pharmacy

NPA National Pharmacy Association

New Charter? What difference will it make?

> IT'S NOT CLEAR WHAT WILL HAPPEN IF THE SOCIETY LOSES THIS VOTE

When an envelope from the Electoral Reform Society landed on my doormat last week, I nearly put it straight into the bin. I wasn't expecting to vote on anything and I knew it couldn't be important.

The Society wants me to approve a new Charter. I don't know why. I only approved the existing one a few years ago and where did that get me? Now, why would I be interested in the Charter of a body that I won't join unless forced?

A number of luminaries are urging me to vote yes, but I've just seen an online survey with 80 per cent of voters against. It's not clear what would happen if the Society loses this vote and I haven't got the time to find out. The official looking document accompanying the ballot paper looks so daunting I bet nobody reads it.

I'll probably treat this matter in the same way as most of my colleagues. That is, ignore it until it goes away. Most of us are so wrapped up in simply getting through the working day that we can think of little else.

The best way that Steve Churton can get our attention is to walk into the pharmacy and ask for some advice. He will then be guaranteed up to five minutes of undivided attention.

And if he wants to help with something that matters – simply helping out in the dispensary for 15 minutes so we can have a cup of tea would earn him respect like nothing else.

The average community pharmacist simply doesn't have the time or the energy for these political machinations. The figures show what they are really interested in: fewer than 150 pharmacists attended the Transcom roadshows and 130 bothered with the recent SGM. Compare this to the 10,000 who made their views heard over the Society's hike in retention fees.

Community pharmacists are increasingly no more than a group of over-worked employees and locums and stressed contractors. They need a union, not a professional body. They need an organisation that stands up for their rights, rather than burdening them with more problems.

Well done, by the way, to John Turk of the NPA for sticking a metaphorical two fingers up to the manufacturers on our behalf (C+D, June 27, p5). I would have done it myself if I wasn't worried about them tightening up my quotas still further.

The Charter vote is only one of a huge number of regulatory changes going on around me at the moment. Most seem to have little or no impact on me, but it can be no coincidence that so many supposedly momentous changes are happening simultaneously. I can't help thinking that all these changes will suddenly combine into one big asteroid that will come crashing down on me. I'm not ready if it does.

A new code to reflect new roles

My congratulations and sincere thanks to PSNI for all the hard work that went into producing the revised Code of Ethics launched in June, and active from July 1. The code clarifies the roles and responsibilities of the modern pharmacist. It is much more patient-focused than previous codes and attempts to cover our expanding range of activities. Pharmacist prescribing, for example, is a new innovation, as are pharmacy internet services.

Gone is any mention of looking after the interests of the profession or the science of pharmacy that are strongly reflected in the Pharmacy Order. In keeping with the current zeitgeist, the patient is king and the patient's needs are paramount. I don't have a problem with this and I'm sure that if we all comply with these standards then we will never have cause to make a visit to the statutory committee.

Indeed, as Baroness Jill Pitkeathley, chair of CHRE, said at the launch in Parliament Buildings, the trick is to produce a code of ethics that protects the public from the charlatan while not stymieing innovative practice. In practice, things, rather than being black or white, are mostly shades of grey. Where actions are in the best interest of the patient and performed to a high standard, the pharmacist can seldom go wrong even where the law is broken. The new code of ethics reaffirms this.

Where the code addresses e-pharmacy, I am concerned that pharmacists' enthusiasm with the internet might become a problem. It is impossible to be certain the patient you are dealing with online is who they say they are in terms of age, sex, co-morbidities, disease history, etc. This is a problem in the supply of POM medicines as well as many P medicines – EHC and Alli are two that spring to mind and might be more easily abused via a visit to an internet pharmacy than via a visit to the bricks and mortar version. We need to do better here.

Another area of emerging practice that concerns me, and one that is likely to bring the profession into disrepute eventually, is the lucrative area of complementary medicines.

I would argue that this area of practice is unethical. How can a pharmacist sell homeopathic remedies if he wishes to comply with principle 7 of the code: to act with honesty and integrity? Homeopathy is not effective in symptom or disease management, it is a placebo at best; as scientists we should know this. This is not opinion, this is scientific fact. As health minister Michael McGimpsey said at the launch, the standard that we set for ourselves should be much higher than the standard others set for us.

Terry Maguire is a community pharmacist in Northern Ireland

> GONE IS ANY MENTION OF LOOKING AFTER THE INTERESTS OF THE PROFESSION

IMPORTANT SAFETY INFORMATION
LICENCE CHANGE FOR TACROLIMUS[1]

Inadvertent, unintentional or unsupervised switching of immediate- or prolonged-release formulations of tacrolimus is unsafe.[1]

This can lead to graft rejection or increased incidence of side effects, including under- or over immunosuppression, due to clinically relevant differences in systemic exposure to tacrolimus.[1,2]

Patients should be maintained on a single formulation of tacrolimus with the corresponding daily dosing regimen; alterations in formulation or regimen should only take place under the close supervision of a transplant specialist.[1,2]

Following conversion to any alternative formulation, therapeutic drug monitoring must be performed and dose adjustments made to ensure that systemic exposure to tacrolimus is maintained.[1,2]

References: 1. ADVAGRAF Summary of Product Characteristics. **2.** Drug Safety Update MHRA January 2009, Volume 2, Issue 6.

Prograf® and ADVAGRAF® have different indications and dosing

Prograf
Tacrolimus

Prograf® is an **immediate release** formulation intended for twice-daily dosing, once in the morning and once in the evening

ADVAGRAF®
tacrolimus prolonged release

ADVAGRAF® is a **prolonged release** formulation for once-daily administration in the morning

Make sure your patient gets the correct brand of tacrolimus

Prevent errors, prescribe by brand

For further information visit:
www.mhra.gov.uk/Publications/Safetyguidance/DrugSafetyUpdate/CON035989
www.emc.medicines.org.uk/medicine/19814/SPC/Advagraf

Prescribing information can be found overleaf

astellas
Leading Light for Life

Presentations: ADVAGRAF® Prolonged-release hard capsules containing tacrolimus 0.5 mg, 1 mg and 5 mg. PROGRAF® hard capsules containing tacrolimus 0.5 mg, 1 mg and 5 mg. **Indications:** ADVAGRAF® and PRDGRAF®: Prophylaxis of transplant rejection in adult liver or kidney allograft recipients and treatment of allograft rejection resistant to treatment with other immunosuppressive medicinal products. **Posology and Administration:** ADVAGRAF® and PROGRAF® therapy require careful monitoring by adequately qualified and equipped personnel. Either drug should only be prescribed, and changes in immunosuppressive therapy initiated, by physicians experienced in immunosuppressive therapy and the management of transplant patients. Dosage recommendations given below should be used as a guideline. ADVAGRAF® or PROGRAF® are routinely administered in conjunction with other immunosuppressive agents in the initial post-operative period. The dose may vary depending on the immunosuppressive regimen chosen. Dosing should be based on clinical assessments of rejection and tolerability aided by blood level monitoring. To suppress graft rejection immunosuppression must be maintained so no limit to the duration of oral therapy can be given. The daily dose of ADVAGRAF® capsules should be taken once daily in the morning with water at least 1 hour before or 2-3 hours after a meal. PRDGRAF® Capsules should be taken as for ADVAGRAF® in two divided doses. ADVAGRAF® In stable patients converted from PRDGRAF® (twice daily) to ADVAGRAF® (once daily) on a 1:1 (mg:mg) total daily dose basis the systemic exposure to tacrolimus for ADVAGRAF® was approximately 10% lower than for PROGRAF®. The relationship between tacrolimus trough levels (C_{24}) and systemic exposure (AUC_{0-24}) for ADVAGRAF® is similar to that of PROGRAF®. When converting from PROGRAF® capsules to ADVAGRAF® trough levels should be measured before and within two weeks after conversion. In *de novo* kidney and liver transplant patients AUC_{0-24} of tacrolimus for ADVAGRAF® on Day 1 was 30% and 50% lower respectively, when compared with that for PROGRAF® at equivalent doses. By Day 4, systemic exposure as measured by trough levels is similar for both kidney and liver transplant patients with both formulations. Race: In comparison to Caucasians, Afro-Caribbean patients may require higher tacrolimus doses to achieve similar trough levels **Prophylaxis of transplant rejection – liver and kidney:** Initial dose of ADVAGRAF® and PROGRAF® Capsules is 0.10-0.20 mg/kg/day for liver transplantation and 0.20-0.30 mg/kg/day for kidney transplantation starting approximately 12 -18 hours for ADVAGRAF® and 12hrs for PROGRAF® after completion of liver or within 24 hours of completion of kidney transplant surgery. Dose adjustment post-transplant: ADVAGRAF® and PROGRAF® doses are usually reduced in the post-transplant period. It is possible in some cases to withdraw concomitant immunosuppressive therapy leading to ADVAGRAF® monotherapy or PROGRAF® dual therapy or monotherapy Post-transplant improvement in the condition of the patient may alter the pharmacokinetics of tacrolimus and may necessitate further dose adjustments. Dose recommendations – Conversion to ADVAGRAF®: Patients maintained on twice daily PROGRAF® requiring conversion to once daily ADVAGRAF® should be converted on a 1:1 (mg:mg) total daily dose basis. Following conversion, tacrolimus trough levels should be monitored and if necessary dose adjustments made. Care should be taken when converting patients from ciclosporin-based to tacrolimus-based therapy. Initiate ADVAGRAF® after considering ciclosporin blood concentrations and clinical condition of patient. Delay dosing in presence of elevated ciclosporin blood levels. Monitor ciclosporin blood levels following conversion. Dose recommendations – Rejection therapy: For conversion of kidney and liver recipients from other immunosuppressants to once daily ADVAGRAF®, begin with the respective initial dose recommended for rejection prophylaxis. In adult heart transplant recipients converted to ADVAGRAF®, an initial oral dose of 0.15 mg/kg/day should be administered once daily in the morning. For other allografts, see SPC. Dose adjustments in specific populations: See SPC. Target whole blood trough concentration recommendations: Blood trough levels for ADVAGRAF® should be drawn approximately 24 hours post-dosing, just prior to the next dose, for PROGRAF® approximately 12 hours post-dosing. Frequent trough level monitoring in the first two weeks post-transplant is recommended, with periodic monitoring during maintenance therapy. Monitoring is also recommended following conversion from PRDGRAF® to ADVAGRAF®, dose adjustment, changes in the immunosuppressive regimen, or co-administration of substances which may alter tacrolimus whole blood concentrations (see 'Warnings and Precautions' and 'Interactions'). Adjustments to the ADVAGRAF® and PRDGRAF® dose regimen may take several days before steady state is achieved. Most patients can be managed successfully if tacrolimus blood concentrations are maintained below 20 ng/mL. In clinical practice, whole blood trough levels have been 5-20 ng/mL in liver transplant recipients and 10-20 ng/mL in kidney transplant recipients early post-transplant, and 5-15 ng/mL during maintenance therapy. **Contraindications:** Hypersensitivity to tacrolimus or other macrolides or any excipient. **Warnings and Precautions:** Medication errors, including inadvertent, unintentional or unsupervised substitution of immediate- or prolonged-release tacrolimus formulations, have been observed. This has led to serious adverse events, including graft rejection, or other side effects which could be a consequence of either under- or over-exposure to tacrolimus. Patients should be maintained on a single formulation of tacrolimus with the corresponding daily dosing regimen; alterations in formulation or regimen should only take place under the close supervision of a transplant specialist. ADVAGRAF®: only limited experience in non-Caucasian patients and those at elevated immunological risk. ADVAGRAF® and PRDGRAF®: During initial period routinely monitor blood pressure, ECG, neurological and visual status, fasting blood glucose, electrolytes (particularly potassium), liver and renal function tests, haematology parameters, coagulation values, and plasma protein determinations; consider adjusting the immunosuppressive regimen if clinically relevant changes are seen. Herbal preparations, including those containing St. John's Wort, should be avoided. Extra monitoring of tacrolimus concentrations is recommended during episodes of diarrhoea. Avoid concomitant administration of ciclosporin. Ventricular hypertrophy or hypertrophy of the septum (reported as cardiomyopathy) have been seen rarely, other risk factors for these conditions include pre-existing heart disease, corticosteroid usage, hypertension, renal or hepatic dysfunction, infections, fluid overload, and oedema. Patients are at increased risk of all opportunistic infections including BK Virus associated nephropathy and JC Virus associated progressive multifocal leukoencephalopathy. Physicians should consider this in their differential diagnosis in immunosuppressed patients with deteriorating renal function or neurological symptoms. Patients have been reported to develop posterior reversible encephalopathy syndrome (PRES). If so radiological tests should be performed. If PRES is diagnosed, adequate blood pressure and seizure control and immediate discontinuation of tacrolimus is advised. Echocardiography or ECG monitoring pre-and post-transplant is advised in high-risk patients, and dose reduction of and or a change of immunosuppressive agent should be considered if abnormalities develop. Tacrolimus may prolong the QT interval. Exercise caution in patients with diagnosed or suspected Congenital Long QT Syndrome. EBV-associated lymphoproliferative disorders have been reported. Concomitant use of other immunosuppressives such as antilymphocytic antibodies increases the risk of EBV-associated lymphoproliferative disorders. EBV-VCA negative patients have been reported to have increased risk of lymphoproliferative disorders; EBV-VCA serology should be ascertained before starting tacrolimus treatment. During treatment, careful monitoring with EBV-PCR is recommended. Exposure to sunlight and UV light should be limited. The risk of secondary cancer is unknown. Capsules contain lactose. **Interactions:** See SPC. **Pregnancy and lactation:** Tacrolimus can be considered in pregnant women when there is no safer alternative. See SPC. **Undesirable effects:** Medication errors have been observed. A number of associated cases of transplant rejection have been reported (frequency cannot be estimated from the available data). Many of the following adverse drug reactions are reversible and/or respond to dose reduction. Very Common (≥1/10): Hyperglycaemic conditions, diabetes mellitus, hyperkalaemia, insomnia, tremor, headache, hypertension, diarrhoea, nausea, renal impairment. Common (≥1/100 to <1/10): haematological abnormalities, hypomagnesaemia, hypophosphataemia, hypokalaemia, hypocalcaemia, hyponatraemia, fluid overload, hyperuricaemia, appetite decreased, anorexia, metabolic acidoses, hyperlipidaemia, hypercholesterolaemia, hypertriglyceridaemia, anxiety symptoms, confusion and disorientation, depression, mood disorders and disturbances, nightmare, hallucination, seizures, disturbances in consciousness, paraesthesias and dysaesthesias, peripheral neuropathies, dizziness, writing impaired, vision blurred, photophobia, eye disorders, tinnitus, ischaemic coronary artery disorders, tachycardia, haemorrhage, thromboembolic and ischaemic events, peripheral vascular disorders, vascular hypotensive disorders, dyspnoea, parenchymal lung disorders, pleural effusion, pharyngitis, cough, nasal congestion and inflammations, gastrointestinal inflammatory conditions, gastrointestinal ulceration and perforation, gastrointestinal haemorrhages, stomatitis, ascites, vomiting, gastrointestinal and abdominal pains, constipation, flatulence, bloating and distension, loose stools, hepatic enzymes and function abnormalities, cholestasis and jaundice, hepatocellular damage and hepatitis, cholangitis, pruritus, rash, alopecias, acne, sweating increased, arthralgia, muscle cramps, limb and back pain, renal failure, oliguria, renal tubular necrosis, nephropathy toxic, bladder and urethral symptoms, asthenic conditions, febrile disorders, oedema, blood alkaline phosphatase increased, weight increased, body temperature perception disturbed, primary graft dysfunction. Uncommon (≥1/1000 to <1/100): coagulopathies, coagulation and bleeding analyses abnormal, pancytopenia, hypoproteinaemia, hyperphosphataemia, hypoglycaemia, coma, central nervous system haemorrhages and cerebrovascular accidents, paralysis and paresis, encephalopathy, speech and language disorders, amnesia, cataract, arrhythmias, cardiac arrest, heart failures, cardiomyopathies, infarction, deep venous thrombosis, shock, respiratory failures, respiratory tract disorders, asthma, paralytic ileus, peritonitis, acute and chronic pancreatitis, anuria, haemolytic uraemic syndrome, uterine bleeding, psychotic disorder, multi-organ failure. Rare (≥1/10,000 to <1/1000): thrombotic thrombocytopenic purpura, blindness, neurosensory deafness, pericardial effusion, acute respiratory distress syndrome, subileus, pancreatic pseudocyst, hepatic artery thrombosis, venoocclusive liver disease, toxic epidermal necrolysis (Lyell's syndrome). Very rare (<1/10,000 including isolated reports): hepatic failure, bile duct stenosis, Stevens Johnson syndrome, nephropathy, cystitis haemorrhagic, Neoplasms. Consult the SPC for complete information on side effects and full prescribing information. **Package Quantities, Basic NHS cost & Product licence numbers:** ADVAGRAF®/PRDGRAF®: 0.5 mg capsules x 50 = £40.57 (EU/1/07/387/002)/£63.13 (PL 13424/0004), respectively. 1 mg capsules x 50 = £81.14 (EU/1/07/387/004)/£81.90 (PL13424/000), respectively. 1 mg capsules x 100 £162.28 (EU/1/07/387/006)/£163.78, (PL 13424/0001) respectively. 5 mg capsules x 50 £405.71 (EU/1/07/387/008)/£302.56, (PL 13424/0002), respectively **Legal Classification:** POM. **Date of Revision:** April 2009. Further information available from Astellas Pharma Ltd, Lovett House, Lovett Road, Staines TW18 3AZ. ADVAGRAF® and PROGRAF® are registered trade marks. **For medical information phone 0800 783 5018**

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Astellas Pharma Ltd – 0800 783 5018

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Features

Update: July is Heart Health Month

The first of four articles looks at the effects of lifestyle on the CV system

Practical Approach

A chauffeur with diabetes wants to know why he is still having 'hypos'

Practice

What can we learn from the USA model of pharmacy?

Category M Barometer

Generic Eric looks at what's happened in the last quarter and how it will affect you

Business

Georgina Craig examines the rise of social enterprise and its impact on pharmacy

Jobs

Our five-point guide to the C+D Jobs website has everything you need to find your ideal job

Update

July is Heart Health Month

Don't miss our four-part guide to heart disease, starting with lifestyle factors (this week) followed by NHS Health Check screening, blood pressure drugs and cholesterol treatments

Your weekly CPD revision guide Module 1484

CVD guide part 1: lifestyle factors

C+D's Heart Health Month kicks off with a look at the effects of an unhealthy lifestyle on CVD

Rosemary Blackie MRPharmS

60-second summary

How does smoking harm the heart?

In many ways: for example it interferes with blood oxygenation, increases blood pressure and the strain on blood vessels, while tar lines the lungs reducing the area available for oxygen transfer.

Why is obesity bad news?

The heart is under greater stress due to having to pump blood to a larger body. This also puts pressure on blood vessels which are narrowed by fatty deposits, further increasing the pressure.

Other harmful factors

Alcohol increases blood pressure, triglycerides and the risk of strokes and arrhythmias. Salt raises blood pressure and excess cholesterol narrows arteries increasing the risk of blockage. Pieces of fatty material may break off, causing heart attack or stroke.

This article (Module 1484) can help to meet the following CPD competencies: C1a, C1d, C1a, C1d, C1q, C1o, C2a, C2h, C2e. See http://tinyurl.com/6box7o

July is Update's Heart Health Month, with a series of four articles on cardiovascular disease. This first article looks at factors that lead to cardiovascular disease and is intended to help you explain to patients the damage they can do with an unhealthy lifestyle.

What can go wrong?

The left side of the heart pumps blood round the whole body and the right side to the lungs. The muscle of the left side is therefore thicker to cope with the extra force needed, as well as the greater arterial blood pressure. This system enables efficient distribution of oxygenated blood and other associated substances round the body, and ensures waste product removal. The heart pumps around 8,000 litres of blood per day.

Arteries of ever-decreasing size take oxygenated blood away from the heart and de-oxygenated blood to the lungs. The veins carry de-oxygenated blood back to the heart, except for the pulmonary vein, which returns oxygenated blood from the lungs.

The heart's ability to perform is affected both directly and indirectly as it responds to inputs and outputs from the organs and structures it supplies. Its efficient performance is further complicated by external factors such as diet and lifestyle.

CHD and CVD risk factors

Various guidelines for risk prediction in CHD and CVD have been developed over the years. They will be explained in next week's article.

Risk factors fall into two broad categories: modifiable and non-modifiable (see table 1, overleaf). Smoking, raised blood pressure and cholesterol have been found to account for 90 per cent of CHD risk.[1]

Smoking

- The carbon monoxide produced by smoking sticks to red blood cells to a greater degree than oxygen, so the blood cannot carry enough oxygen to the whole body, resulting in tissue hypoxia.
- Smoking increases blood pressure, increasing strain on blood vessels.
- Tar lines the lungs, reducing the area available for waste removal and oxygen transfer.
- Chemicals in cigarette smoke have a negative impact on all blood vessels, again increasing strain on them and reducing internal area and efficiency.

Smokers who quit will reduce their heart disease risk to the same level as non-smokers by 10 years, but stroke and heart attack risks start to decrease immediately as more oxygen can be transported to the organs. The atherosclerosis rate starts to decrease as tar and other harmful chemicals are no longer pumped into the body.

Obesity

- The heart has to exert greater pressure to ensure blood gets to all areas.
- The heart exerts greater pressure on blood vessels as a result of its harder work. Blood vessels are likely to be narrowed by accumulation of fatty deposits, therefore reducing area available to absorb the pressure of the pumping heart, further increasing pressure on the vessels.

For every 1kg weight loss, there is about 1mmHg blood pressure decrease, in a linear relationship.

Obesity is even more of a problem if the excess fat is around the waist. Fat cells secrete adipocytokines, which contribute to the process of atherosclerosis. Adiponectin is a beneficial secretion from the same cells, but less is produced in central obesity.[2] So it is not just the BMI that is important in assessing CVD risk; waist circumference is an independent risk factor (see table 2 on page 16).

Alcohol

Excessive alcohol consumption affects the CV system by:

- being high in calories, with little nutritional value
- increasing triglyceride levels
- increasing blood pressure
- increasing the risks of stroke and arrhythmias.

The NHS advice is that men should not drink more than three to four units of alcohol a day and women no more than two to three units daily.

There is evidence that moderate drinking (within the current guidelines with at least one or two alcohol-free days each week) can increase HDL-cholesterol levels. Alcohol also reduces platelet coagulation for 24 to 48 hours and has beneficial effects on fibrinogen and fibrinolysis.

However, this evidence should not be used to advise someone to start drinking alcohol, as HDL cholesterol can be increased by other dietary changes, exercise and stopping smoking, to give

greater and safer beneficial effects on the cardiovascular system.

Cholesterol

When there is too much cholesterol, the liver is unable to process it all for removal. The excess lines the arteries, making them narrower and increasing pressure and the risks of blocking and rupture.

Pressure in the bloodstream can cause pieces of the lining to break off and travel round the body until reaching a vessel too narrow to pass through. This causes angina, heart attack or stroke. Chemical influx in response to the injury causes oedema, with more stress and damage.

But cholesterol does have beneficial effects. It is needed for normal cell functioning and is the basis for certain hormones. HDL-cholesterol reduces and prevents atheroma formation and is required to transport cholesterol away from the arteries to the liver for processing and removal.

Salt

Salt's negative impact is to raise blood pressure by causing water retention, increasing pressure on the blood vessels. It is the sodium that causes this increase (sodium content of 1g salt is 0.4g). Some salt is needed, but no more than 6g per day. Monitoring salt intake can be difficult, as it is added to many foods. Effervescent analgesics contain large amounts of sodium (further information on sodium in medicines is at www.nelm.nhs.uk). Salt substitutes often contain sodium as well as potassium, which could result in hyperkalaemia if consumed in excess.

Diabetes

Diabetes can increase CVD risk up to five times. Poor glucose control, low HDL cholesterol and increased triglycerides (a feature of type 2 diabetes) increase atherosclerosis. Increased urinary protein excretion (microalbuminuria) induced by hyperglycaemia also increases CVD risk.

Changing lifestyles

Next week's Update will concentrate on how you can assess cardiovascular risk and encourage people to reduce their risk factors. People often find it hard to change their lifestyle because they 'feel fine' and do not perceive there is a risk, but the chances are that they will feel and look a great deal better if they adopt this advice. Explaining how each risk factor plays a part and how the recommended changes reduce this risk increases the likelihood of sustainable change.

Emphasising that one change, such as increasing exercise or stopping smoking will have a beneficial effect on many risk factors, can make it seem less onerous – important when one of the excuses for not continuing with modifications is being 'too busy'.

Remember, too, that prevention is much less effort than treating the possible serious consequences.

Rosemary Blackie is a community pharmacist in Sheffield.

Get an RPSGB-approved CPD certificate for your portfolio when you successfully complete the 5 Minute Test online. See opposite for details.

References and further information are online at www.chemistanddruggist.co.uk/update

Glossary of common heart problems

- **Atherogenesis** Formation of atheroma, a fatty deposit lining the artery
- **Atherosclerosis** Also known as arteriosclerosis or hardening of the arteries, this is formation of fibrous deposits over fatty atheroma cores as a result of chronic inflammation of the endothelial cells lining the arteries (see the explanation in the full version of this article online at www.chemistanddruggist.co.uk/update)
- **Angina** Chest pain due to reduced blood flow to the heart muscle, relieved by rest
- **Arrhythmia** Loss of normal heartbeat rhythm. There are several types, depending on frequency and the area of the heart in which the arrhythmia starts
- **Coronary heart disease (CHD)** Diseases or conditions affecting the heart. Heart disease is not only directly related to events within the heart, but also is often affected by vascular system function. As a result, guidelines now refer to CVD rather than CHD
- **Coronary vascular disease (CVD)** Diseases affecting the heart and vascular system
- **Heart attack (myocardial infarction)** Complete blockage of oxygen supply to an area of the heart muscle, resulting in hypoxia and tissue death
- **Heart failure** This is the situation when the overall ability of the heart to pump efficiently is compromised. It can develop as a result of other heart disease. In left ventricular systolic dysfunction, the left ventricle does not pump all the blood out to the body. In diastolic dysfunction, the left ventricle does not fill up to its full capacity when receiving blood from the left atrium (from the lungs)
- **Hypertension** High blood pressure defined by the JBS2 Guidelines as over 140/90mmHg. Over 130/80mmHg is considered high for people with diabetes or those with established CVD disease or chronic renal failure
- **Peripheral vascular disease** Narrowing of the blood vessels to areas of the body other than the heart and brain
- **Stroke – haemorrhagic** Tissue death in the brain as a result of blood vessel rupture, resulting in symptoms specific to the brain area affected
- **Stroke – thrombotic** Obstruction of blood vessels in the brain by clots to cause tissue death and symptoms specific to the affected area
- **Transient ischaemic attack (TIA)** Temporary blockage in the brain (mini-stroke) lasting less than 24 hours.

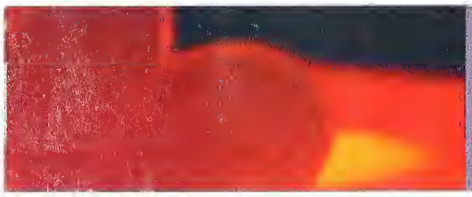
Table 1: Modifiable and non-modifiable risk factors in CHD and CVD

Modifiable	Non-modifiable
Weight	Age
Blood pressure	Sex
Diet	Genetics
Exercise	Race
Lifestyle	Early menopause
Smoking status	
Cholesterol level	
Blood glucose level	

Table 2: Assessment of risks from BMI and waist circumference (from Nice clinical guideline 43)

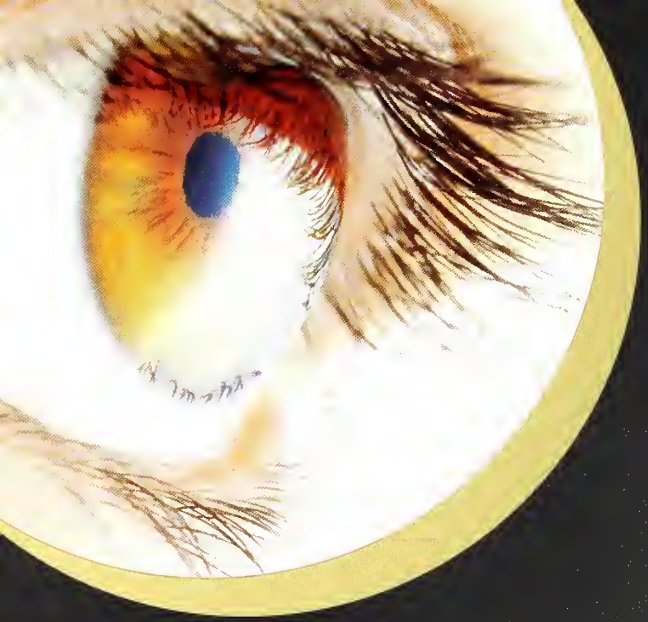
BMI	Low weight circumference	High waist circumference	Very high waist circumference
Overweight BMI 25-29.9	No increased risk	Increased risk	High risk
Obesity BMI 30-34.9	Increased risk	High risk	Very high risk

Waist circumference women: low less than 80cm, high 80-88cm, very high over 88cm.
Waist circumference men: low less than 94cm, high 94-102cm, very high over 102cm.



NEXT WEEK'S UPDATE

CVD guide part 2: Vascular risk assessments under the NHS Health Check screening programme



GoldenEye®

A handy guide to some common eye conditions

Conjunctivitis

Conjunctivitis

In conjunctivitis (sometimes referred to as 'red' or 'pink eye'), the material covering the white part of the eye and lining the inner parts of the eyelid, called the conjunctiva, becomes inflamed.

This inflamination results in excessive tearing, pain and itchiness. Also, a creamy white discharge from the eye is often present.

Conjunctivitis is caused by either bacterial infection, viral infections or allergies.

Styes

Styes

Styes develop when a gland at the edge of the eyelid becomes infected. Resembling a pimple on the eyelid, a stye can grow on the inside or outside of the lid.

Styes can cause pain, redness, tenderness and swelling, as well as frequent watering of the eye.

Styes are caused by staphylococcal bacteria.

Blepharitis

Blepharitis

Blepharitis is the medical term for inflamed eyelids. The inflammation is like eczema of the skin, with red, scaly eyelids. Sufferers may notice red, tired, or gritty eyes which may be uncomfortable in sunlight or a smoky atmosphere.

Blepharitis is caused when the glands in the eyelid become infected, causing inflammation which leads to uneven 'tear' production, resulting in dry patches developing on the surface of the eye.

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Isetionate 0.15% w/w

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○ Allergy ○ Bacteria

2. Can GoldenEye's Antibiotic formulations be used to treat acute bacterial conjunctivitis?

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CVD guide part 1: lifestyle factors

Reflect

How quickly does the risk of stroke and heart attack decrease after stopping smoking? Why is waist circumference important in assessing CVD risk? How does excess dietary salt increase blood pressure?

Plan

This article describes the main problems that can affect the heart. It explains why smoking, obesity, cholesterol and excess alcohol are risk factors for CVD.

Act

Read the full version of this article on the C+D website at www.chemistanddruggist.co.uk/update.

Read more about atherosclerosis and CVD risk factors on the Patient UK website at http://tinyurl.com/pwxo4v.

Other Patient UK articles that may be useful revision include angina at http://tinyurl.com/q2trq6 and myocardial infarction at http://tinyurl.com/ocsm9l.

Update your knowledge of arrhythmia from the Arrhythmia Alliance website: http://tinyurl.com/pg4tes.

Find out more about the effects of smoking on heart disease from the Ash website at http://tinyurl.com/qlt8kc.

Read more about the functions of cholesterol and lipoproteins and how they can affect heart disease from the Heart UK website at http://tinyurl.com/qzt3au.

Evaluate

Do you know the risk factors for CVD and how these factors increase that risk? Could you explain to a patient the effects of smoking, obesity and alcohol on the heart and vascular system?

5 minute test

What have you learned?

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Step 2

Access the 5 Minute Test questions on the C+D website at www.chemistanddruggist.co.uk/cpd

Step 3

Use your PIN to complete the assessment online or phone through your answers. Your test score will be recorded. If you successfully complete the 5 Minute Test online you will also be able to download an RPSGB-approved CPD certificate

Registering for Update 2009 costs £32.50 (inc VAT) and can be done easily at www.chemistanddruggist.co.uk/update or by calling 01732 377269. Signing up also ensures that C+D's weekly Update article is delivered directly to your inbox free every week with C+D's email newsletter.

Get an RPSGB-approved CPD certificate for your portfolio when you successfully complete the 5 Minute Test online

Practical Approach

'Hypos' in diabetes

Roy Martin brings his repeat prescription into the Update Pharmacy and asks to speak to pharmacist David Spencer, who comes out to see him.

"I don't know if there's any point in taking these medicines," Roy says.

"Why do you say that?" David asks.

"Well, I'm trying hard but I seem to be taking all these tablets every day for nothing. I'm still getting hypos, and quite often. Nothing serious has happened yet, but it's beginning to worry me because I drive for a living – I've got my own chauffeuring business – and I wouldn't want anything to happen while I'm at the wheel. And I'm still putting on weight."

"Have you discussed this with your GP?" David asks.

"Not yet. I was thinking about it when I last went to see him a month ago but he did a blood test and said I was doing very well, so I didn't mention it. He said all my measurements were pretty good. Look, it's all here on my record card. He said that perhaps I needed to get my blood sugar down a bit more, so he upped the dose of the gliclazide."

David looks at the card, which gives the following information: Blood pressure 130/80 mmHg; total cholesterol 3.9 mmol/L; HDL1.3mmol/L; HBA1c 7.4 per cent; BMI 33; renal and liver function normal.

From the PMR, David sees that Mr Martin is 56 years old and has been taking medication for diabetes for four years. His current prescription is for metformin 1g bd; gliclazide 160mg bd, ramipril10mg daily, amlodipine 10mg daily; aspirin 75mg daily; simvastatin 40mg on.

Questions

1. Is Mr Martin's blood sugar level too high?
2. Could David suggest any medication modifications that might help Mr Martin?
3. What advice could or should David offer to Mr Martin?

Answers

1. An HBA1c of less than 7.5 per cent is generally thought to be an acceptable level in most cases, (although Nice guidelines give an ideal figure of less than 6.5 per cent) and was the threshold level at which the General Medical Services contract rewarded GPs financially for achieving with their diabetic patients. However, this target was recently lowered to less than 7 per cent and this may be the reason why Mr Martin's gliclazide dose was raised.

2. Sulphonylureas, of which gliclazide is one, can cause hypoglycaemia and it may be advisable to change this to a thiazolidinenedione ('glitazone'), as they are the hypoglycaemic agents least associated with this effect, although it may contribute to weight gain. Sitagliptin, a dipeptidylpeptidase-4 (DDPIV) inhibitor, is another option as it is weight gain neutral.

3. Encourage him to continue with his medication as generally it is working well, and emphasise the importance of controlling blood pressure and lipid levels in diabetes. Suggest that he asks his GP for referral to a dietetic service to help reduce his weight. Strongly advise him, for safety reasons, to stop driving until the hypoglycaemic attacks have stopped.

This article can help with these CPD competencies: **G1a, G1c, G1d, G1e, G2o, C1a, C1b,C1c, C1d, C3e**
See http://tinyurl.com/68ox7b

To see the full archive of Practical Approach articles go to **www.chemistanddruggist.co.uk/practicalapproach**

The American dream

As Independence Day dawns, **Zoe Smeaton** and **Sheena Kanabar** look across the Atlantic to find what lessons UK pharmacy can learn from going stateside

Ram raids on stores, speculations about a certain King of Pop's medication and serial pharmacy robbers. Search USA pharmacy on Google News and some of the results could leave you thinking the profession stateside is hardly something to aspire to. But dig a little deeper and you find pharmacy is another area where the USA is a world superpower.

David Pruce, director of policy and communications at the RPSGB, certainly thinks so. Mr Pruce says in the USA pharmacists are really focusing on what they can do for patients. "There are some very innovative and exciting things... they're taking a holistic approach to patients," he explains.

In the USA much focus has been centred on a concept of 'pharmaceutical care' developed by pharmacy practice researchers who described the concept as being patient-centred and based around identifying, resolving and preventing drug related problems. John Norton, public relations manager at the USA's National Community Pharmacists Association, says pharmacists have an emphasis on working collaboratively with patients. Part of this has included adopting a more clinical role, and some of the directions they are going in could be good for pharmacists here too.

Andy Seger, a senior research pharmacist with Partners Healthcare, a non-profit health system in the USA, says: "There are some patient care centres at chains such as Walgreens that monitor patients for diabetes, high cholesterol, hypertension and anticoagulation." And on vaccinations the USA has made more progress than the UK, as the American Pharmacists Association says "more than half of the states in this country allow pharmacists to provide immunisations". In other states pharmacies are still encouraged to get involved by hosting clinics and conducting public education activities, all ideas UK pharmacists could consider.

With such a focus on clinical services, the USA has even adapted its pharmacy training model to cope. Mr Norton explains that a pharmacy qualification used to be completed within five years but now generally takes six. "That additional year is purely clinical," he says. And Mr Pruce says this is a very interesting model. "I'm certainly interested in seeing how it works and whether it lives up to the promises," he says.

> WITH A FOCUS ON CLINICAL SERVICES, THE USA HAS EVEN ADAPTED ITS TRAINING MODEL FOR PHARMACY

But there are many challenges for USA pharmacy. As PSNC chief executive Sue Sharpe points out: "In a largely privately funded [health] system, services have to be contracted for with a large number of different payers." Pharmacists in the USA receive both funding from the government through schemes to help economically disadvantaged patients and those aged over 60, but also from insurers and patients themselves. And this can create administrative burdens. Mr Norton says this is "probably the biggest challenge" faced in the USA, but that pharmacists have coped by focusing on working to systems to try to restrict the time spent on this.

Competition in the American market is also tough, particularly for independents, and particularly with the rise in internet and mail order pharmacy. Yet Mr Norton says the number of independents has been "pretty stable" over the last few years and they are competing with the large chains.

He advises: "The emphasis is on patient service; if you provide that they will come back." He says some pharmacies are "staking out" certain markets, such as in rural areas where they will often be the only healthcare professional available. Others are covering niches such as providing hard-to-access drugs, or very expensive items to draw in particular customers.

On the subject of pharmacy security, it can still be an issue, but many pharmacies have surveillance equipment and can find advice and discounts from the pharmacy bodies. Mr Seger says some pharmacies refuse to stock certain drugs, instead sending prescriptions to a central facility to be processed. With C+D reporting on a London pharmacist recently attacked with acid, perhaps we'll be taking some of these lessons on board sooner rather than later.

But it's not all about what we can take from them, as there are also some lessons they can learn from us. For example, in the USA pharmacy is currently pushing to have some medicines available without a prescription, but only from pharmacists, as we have here. So although it's all eyes across the pond this weekend, perhaps in future the lessons will be learnt both ways.

USA vital statistics

- 112,000 community pharmacists
- 66,000 pharmacists in chains and 46,000 in independents
- 3.54 billion scripts processed in the USA in 2008
- 0.3% increase in script volumes in 2008
- 2% – mail order pharmacies' share of 2008 pharmacy retail sales
- 44.6% – chain drug stores' share of 2008 pharmacy retail sales
- 53.2% – independents' share of 2008 pharmacy retail sales

Sources: American Pharmacists Association and National Association of Chain Drug Stores

Springboard

Springboard Pre-registration Training Programme

The **Medway School of Pharmacy**, in partnership with **C+D**, is launching **Springboard**, an exciting new pre-registration training programme. **Springboard** will cover all aspects of the community pharmacy experience and assist the trainee in making a smooth transition from student to professional.

The programme will consist of eight in-house study days covering:

- Responding to symptoms
- Law and Ethics
- Controlled Drug regulations
- Medicines use reviews
- Drug Tariff
- Pharmaceutical calculations
- Dressings and wound management
- Monitored dose units
- Smoking cessation
- Drug misuse
- Management
- Communication skills
- First aid
- The NHS and how it works
- Influencing your PCT
- Auditing your services
- Clinical cases using the BNF
- Practice exam questions

The programme will enable the student to meet the appropriate competences in the RPSGB pre-registration student handbook, and offer support to pre-reg tutors. There will also be a tutor training day. Students will have access to a member of staff at the university and the university's facilities.

This programme is unique in that students will have the opportunity to be accredited to provide medicines use reviews. Additionally students will be able to accumulate credits by completing distance learning courses included in the programme that can be put towards a postgraduate qualification.

All eight student study days and the tutor day will be held at Medway School of Pharmacy in Kent. The cost of the full course is £1,500 +VAT per student.

For more information on the **Springboard** course, complete the slip below and return to:
Pauline Sanderson, C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

☐ **YES**, please send me more information on the **Springboard** pre-registration training programme

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Category M Barometer

How will this quarter's tariff changes affect your business?

In such a financially volatile business environment, the latest category M reimbursement tariff provides predictable stability. Again, the Department of Health has employed a 'nip and tuck' policy of making minor tweaks to prices for the third quarter of the year.

Average reimbursement prices in the new tariff decreased by 0.3 per cent, with the pot evenly spread across the entire basket of products. Just seven products registered a fluctuation of more than 20 per cent.

This equates to a negative adjustment of £3.7 million across the sector for the quarter, or an annualised figure of almost £15m. This has pushed the Category M Barometer down to 93.9 from the previous quarter's figure of 94.2.

Analysis with Generic [illegible]

Of all the 515 products within category M, 246 were reduced and 194 were increased, leaving 75 unchanged. The majority of these unchanged products were the so-called 'penny lines', which had a significant increase in reimbursement price at the end of 2008.

For the most commonly dispensed lines by volume, there was a relatively minimal decline this quarter of £1.2m. The average pharmacy will feel the impact of the reduction in these products through a £31 per month deficit on the bottom line. This slight fall continues the trend established by the Q4 2008 tariff, which introduced an assumed fixed price element.

However, looking at the reimbursement of the most common lines since the inception of category M demonstrates how contractors have suffered over the longer term. For the average pharmacy, this has translated into a shortfall of £8,000 a quarter – or £2,600 a month.

Go to C+D's Category M Barometer page at www.chemistanddruggist.co.uk/catm for more information on category M.

-£3.7m removed this quarter

What's hot

The 10 products with the largest rise in price	Pack size	April tariff price	July tariff price	Change	
Imipramine 10mg tablets	28	1.15	1.48	+£0.33	▲29%
Levethyroxine sodium 25mcg tablets	500	11.08	14.24	+£3.16	▲29%
Nifedipine 5mg capsules	84	2.89	3.70	+£0.81	▲28%
Amoxicillin 3g oral powder sachets sugar free	2	5.43	6.78	+£1.35	▲25%
Nifedipine 10mg capsules	84	3.90	4.86	+£0.96	▲25%
Prednisolone 5mg gastro-resistant tablets	28	4.41	5.30	+£0.89	▲20%
Prednisolone 2.5mg gastro-resistant tablets	28	4.36	5.22	+£0.86	▲20%
Ofloxacin 200mg tablets	10	4.96	5.86	+£0.90	▲18%
Oxybutynin 5mg tablets	56	7.70	9.05	+£1.35	▲18%
Imipramine 25mg tablets	28	1.17	1.37	+£0.20	▲17%

What's not

The 10 products with the largest fall in price	Pack size	April tariff price	July tariff price	Change	
Hydrocortisone 1% cream	50g	14.12	10.68	-£3.44	▼24%
Ramipril 1.25mg tablets	28	1.85	1.42	-£0.43	▼23%
Dipyridamole 25mg tablets	84	3.53	2.89	-£0.64	▼18%
Cefaclor 125mg/5ml suspension sugar free	100ml	5.45	4.53	-£0.92	▼17%
Ofloxacin 400mg tablets	10	5.52	4.59	-£0.93	▼17%
Aspirin 300mg dispersible tablets	100	5.68	4.79	-£0.89	▼16%
Ascorbic acid 500mg tablets	28	3.23	2.79	-£0.44	▼14%
Chlordiazepoxide 5mg capsules	500	15.57	13.60	-£1.97	▼13%
Paracetamol 500mg tablets	32	1.18	1.05	-£0.13	▼11%
Gemfibrozil 600mg tablets	56	33.34	29.79	-£3.55	▼11%

Data and analysis supplied by Actavis

3.7

0.3

1,600

Pounds per year (£133 a month) off the bottom line of the average pharmacy


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The government, famous for pioneering the third way, is pinning its hopes on the third sector to stimulate competition in the NHS in England. But how will the rise of social enterprise impact on community pharmacy, asks **Georgina Craig**

Socially acceptable?

Social enterprises are big news in the NHS. With a business philosophy closely aligned to the public sector but all the benefits of a commercial approach, they are seen as the best of both worlds: a neat fit with modern health services, predicated on competition and choice.

But in many ways the promotion of social enterprise is a case of 'back to the future'. Prior to the creation of the National Health Service in 1958, many healthcare providers were social enterprises. Charities, benevolent societies and not-for-profit organisations abounded. Indeed, the movement has been thriving in the community pharmacy sector for years. The Co-operative, established in 1844 by the Rochdale Pioneers to provide cheap food for local factory workers, has grown to become a UK retail giant, and The Co-operative Pharmacy is the third largest player in the market with almost 800 stores.

"The Co-operative Pharmacy is about pharmacy provision first and foremost, but it is provided and offered with a moral compass," explains John Nuttall, managing director. "In essence, being a co-operative means that, unlike pharmacy chains owned by individuals or shareholders, we are owned by our customer members, and return a share of our profits to the people we trade with."

There are, in fact, seven business models a social enterprise can adopt (see box right). Community interest companies (CIC) are a recent addition. Like any other company, CICs are profit driven, but their strong social mission differentiates them. CICs provide an annual report to their regulator that demonstrates they are working to deliver benefits to their defined community.

In addition, how they use their profits is controlled. A minimum of 65 per cent of CIC profits must be reinvested in providing benefits to the community. CICs also have an asset lock. This means if the company is sold, its assets must be transferred to another CIC or charity.

CIC is the form of social enterprise being most heavily promoted in the NHS. A factor in this is that CIC status offers safeguards against asset stripping that could follow traditional privatisation. Community Services Trusts are currently assessing their links with PCTs and being encouraged to opt for CIC status. If they do, the NHS has promised to maintain NHS pension benefits for staff working for the CIC on the day of transfer. This is a significant subsidy, amounting to as much as 30 per cent of total staff salary bill. But it will be a brave move. Becoming a CIC will require huge cultural change in NHS organisations. It may offer more freedom to get things done, but it also means carrying the full business and financial risk of service provision. CICs will not be able to turn to PCTs to bail them out of any deficits they incur.

Industrial provident societies, such as the Co-operative, are owned by their members. Some are defined as 'community benefits societies'. They do what it says on the tin, and work to provide benefit to their community.

The seventh model is charitable status. Charities are overseen by The Charities Commission, and are limited in terms of the commercial activities they can undertake.

Trying to unpick the difference between a social enterprise and the private sector can be tricky. In the end, it boils down to what drives the business. The thing that all social enterprises have in common is a strong 'social mission' and a commitment to make a difference to the community they serve. Profit is certainly not a dirty word but it is usually contingent on valuing community interest when making business decisions.

So, what does the rise of social enterprise mean for pharmacy? Well, as professional boundaries blur, pharmacy will need to redefine its competition to include other professionals. It is important that pharmacy understands what drives the social entrepreneur's business model and differentiates them. In the health sector more than any other, having a strong social mission is likely to be a unique marketing proposition that resonates well with both commissioners and the general public. It creates credibility and, in an increasingly competitive market, being a social enterprise may be the icing on the cake that wins the contract, so they will be stiff competition.

From another angle, however, social enterprises could be great business allies. With a shared commercial approach to patient care, and the opportunity for pharmacy to lend its commercial expertise to community care CICs, there is an opportunity for joint ventures and formal collaboration across a wide range of core and enhanced pharmacy services for patients under the care of community trusts.

And, in areas where there are gaps in pharmaceutical service provision and the business case for a traditional pharmacy is not sustainable, it might be a case of if you can't beat 'em, join 'em. Pharmacist social entrepreneurs might use the current fashion to set up much needed essential pharmacies, and

Community spirit: Local Care Direct is a community mutual with a turnover of over £19m

could even get grants to help them get started.

In addition, the CIC business model can underpin development of provider consortia. For instance, Slough Health Care CIC is a company owned and set up by all Slough doctors, who invested £1 for every patient on their lists. The SHA also invested innovation money to seed fund the company. Now it is bidding for and delivering a range of primary-care based enhanced services to the people of Slough. There may be an opportunity for pharmacy contractors to become shareholders alongside GPs in companies like Slough Health Care CIC, or to form pharmacy CICs to provide services in a similar way.

Stephen Fishwick, head of external relations at the NPA, sees social enterprise as an interesting opportunity and potentially a desirable model for delivering pharmacy-based services. He says: "Using this model signals a direction of travel that would be attractive to commissioners, and it could open up access to funding streams that may be denied to others."

In whatever form, social enterprises look set to become a part of mainstream NHS service provision.

Georgina Craig is an independent healthcare consultant and former head of communications at the CCA

What is a social enterprise?

Definition

Rather than maximising shareholder value, the main aim of a social enterprise is to make profit to further their social and environmental goals.

Facts

- Approximately 62,000 social enterprises in the UK
- Combined turnover of at least £27 billion
- Account for 5 per cent of all businesses with employees
- Contribute £8.4 billion per year to the UK economy

Types

- Company limited by guarantee
- Company limited by share
- Community Interest Company limited by guarantee
- Community Interest Company limited by share
- Member owned industrial and provident society
- Community benefit I &P S
- Charity

Information courtesy of the Social Enterprise Coalition

CASE STUDY 1: Local Care Direct

Formed from seven merged GP out-of-hours co-operatives, it has a turnover of £19 million and 793 members

Local Care Direct (LCD) is one of the most successful social enterprises commissioned by the NHS. It was formed following the introduction of the 2004 GMS contract from seven merged GP out-of-hours co-operatives.

Overnight, it took on contracts for out-of-hours care across West Yorkshire. Four years on, it has matured into a very successful business with an annual turnover of over £19 million. A community mutual, it has 793 members, including staff, GP members and the local community.

It recently bid for and now runs three equitable access health centres across West Yorkshire alongside the existing out-of-hours business. It also runs a 24-hour on-call service for prisons and, increasingly, is developing its urgent care provision to relieve pressure on GP practices during the day.

Sally Campbell is LCD's pharmaceutical advisor. She liaises with local LPCs and PCT medicines management leads. As an ex-community pharmacist herself, she always tries to include pharmacy referral into LCD's triage systems.

"A national minor ailments scheme would make a big difference to us. We work across four PCTs and the fact that everyone has a different scheme makes it very difficult to have a consistent approach. Keeping up with four different sets of formulary changes is difficult. I am sure our ability to work with community pharmacy would increase with a national scheme."

CASE STUDY 2: Nene Commissioning

One of the country's biggest PBC consortia, it commissions services on behalf of 90 per cent of the county's GPs

Those who doubt that practice-based commissioning (PBC) can deliver should take a trip to Northamptonshire. Just over two years old, Nene Commissioning is one of the biggest PBC consortia in the country and is recognised as a leading edge example of what PBC can achieve. A community interest company, it commissions services on behalf of 90 per cent of the county's GPs, comprising 75 practices, 351 GPs and 650,000 patients.

Chief executive Ben Gowland is keen to stress: "We may only do commissioning, but we are not a proxy PCT. We don't consult. We engage with our clinicians – before and after we implement change. And we talk clinician to clinician, which generally means we speed up delivery and avoid petty politics.

"When we set up, we decided that unless we could deliver significant change within six months then PBC wasn't worth doing. Our clinicians make the decisions, supported by a strong management team to ensure implementation. We are big on customer service and have a 'can do' attitude and culture."

That 'can do' approach has resulted in Nene winning a £3 million contract to expand community nursing to prevent unplanned hospital admissions and expand care closer to home. As part of this, Nene has started a scheme where pharmacy technicians visit patients in their homes post hospital discharge. The technicians remove old medication, and ensure the patient and their carer understand how to deal with any changes to the drug regime. Nene has also commissioned a medicines management service to support local care homes and improve quality of pharmaceutical care.

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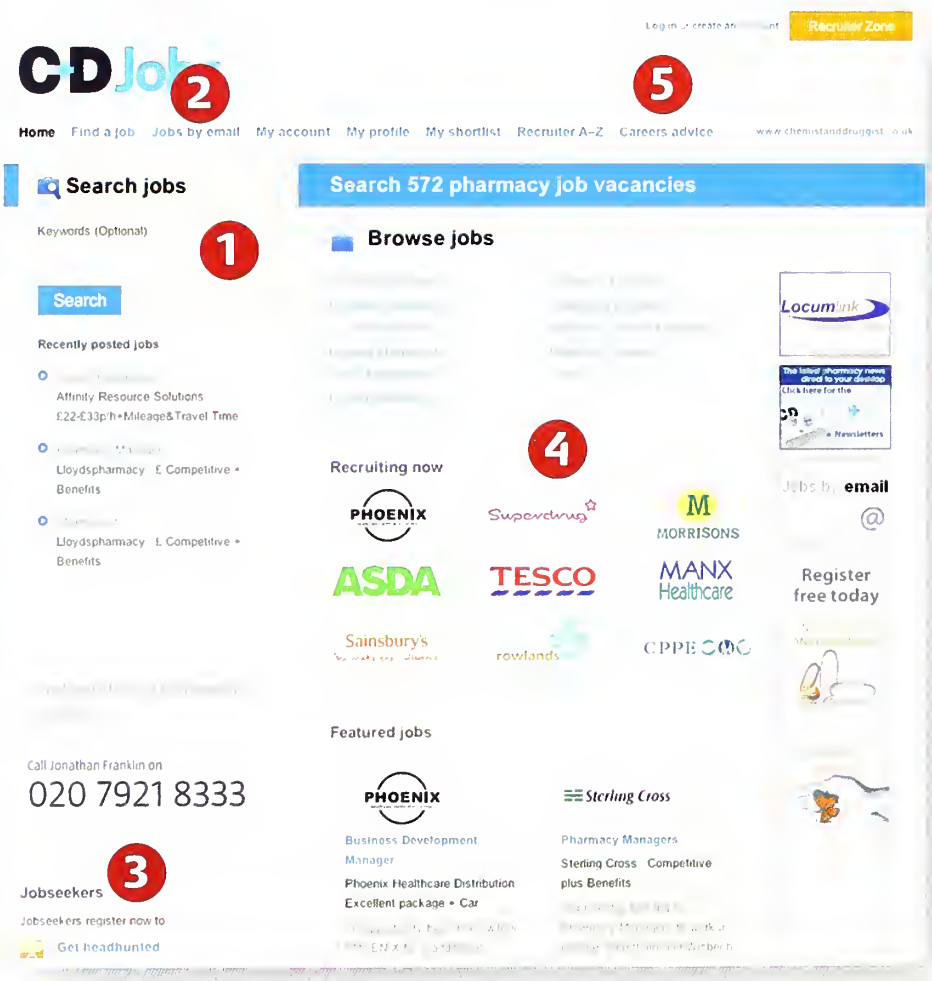

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If you're looking for a new job, making a career change or just want to get more from your working life, the C+D team is on hand with advice. Each week, the C+D Jobs site features an article on topics as diverse as writing the perfect CV, working abroad and how to be a great pre-reg tutor.

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

All for one and one for all

This week I learnt two lessons in herding cats.

Firstly, a few of us independents got together to discuss a couple of issues and went for a curry afterwards. Doesn't sound like much of a feat when you write it on paper, but I know how busy these guys are; my in-tray is piled high with important pieces of paper the PCT wanted yesterday. So I was just pleased that someone made the effort and, who knows, maybe next time we might get a few others along.

It was a very enjoyable evening in the company of people I like, respect and can empathise with. One of my colleagues had been in pharmacy in Dorset for 22 years, but this was one of only a handful of times that some of the independents had got together. One message that I think we all took away with us was that being independent doesn't have to mean you are alone.

I'd urge independents everywhere to talk to each other, share ideas, commiserate and encourage their colleagues. It was interesting the very different viewpoint that we as a group had versus any other gathering of pharmacists I have ever been to: definitely a bit more commercial, but always with a view to the funnier side of life behind the counter!

And secondly one of our cats sparked a bit of excitement when he decided to 'go walkies'. Thankfully, a full scale search and rescue mission by my wife and, it seems, half the town, resulted in his safe return. People are still coming into the shop now asking if we've found the cat!

> ‘BEING INDEPENDENT DOESN'T HAVE TO MEAN YOU ARE ALONE’

Raiders of the lost archives

C+D 1859-2009 Celebrating 150 years in pharmacy

C+D 150

For several months, Postscript has been mining only the first few issues of the massive C+D archives for gleaming nuggets of the bizarre. But while walking past the dark and dingy section that houses the August 1878 issues, we struck comedy gold.

A medicine pipe – for horses.

The picture explains it all: some deranged chemist thought squirting medicines into a horse's throat was too complicated, and figured forcing a pipe down an equine gob would be more effective. Through an elaborate system of pulleys, cogs and valves, any medicine placed in the pipe's bowl would eventually end up in the horse's stomach. Postscript would tell any doubters to put that in their pipe, but given the look of sheer terror on the illustrated horse's face, perhaps it wasn't such a bright idea after all...

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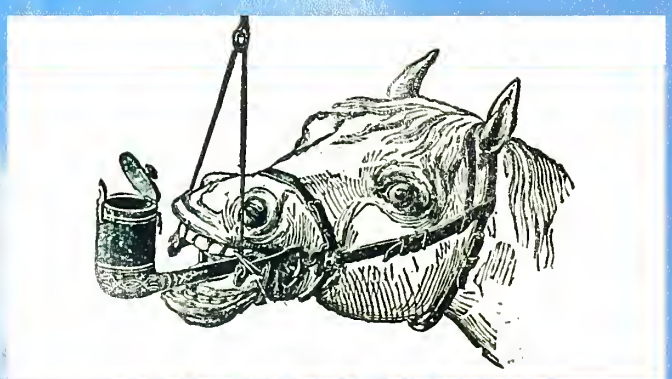

Doctors, discos and the BBC

It's that time of year again and as usual Postscript has been poring over the motions put forward for the annual conference of local medical committees (LMCs). And, happily, this year's batch does not disappoint.

The customer may always be right, but West Pennine LMC doesn't think so. The committee suggests that "the bias inherent in the government's obstinate commitment to a website where patients can comment on their GPs should be redressed by a similar site where GPs can rate their patients".

Others were more frustrated with MPs, with Salford and Trafford LMC suggesting they take some of their own medicine and let their pay be affected by constituents' views of their work. Very timely.

And Postscript can't help thinking that GPs in Northamptonshire were on to something with their suggestion that the Department of Health informs general practices about new relevant initiatives "before informing the BBC".

But best of all Postscript likes the GPs in Glasgow, who suggested the motion that the conference entertainment committee "arrange a disco after the conference dinner". Suggestions for next year's LPC conference motions start here. Email postscript @cmpmedica.com

Right on course with a winner

Welsh pharmacist Hywel Jones is the proud owner of the inaugural winner at the first turf racecourse to open in Britain for over 80 years.

Mr Jones's horse Plunkett took the first race at 15-8 when the Ffos Las track opened in Trimsaran, West Wales, earlier this month.

Mr Jones told Postscript his long working hours as director of TH & L Jones pharmacies meant he rarely got to see the horses run "in the flesh". But he added that his extracurricular passion was not so different to running a successful pharmacy.

"Like any business, to succeed you have to have highly capable and motivated staff," he said. "You must employ the best and in the trainer Evan Williams I have a great stockman."

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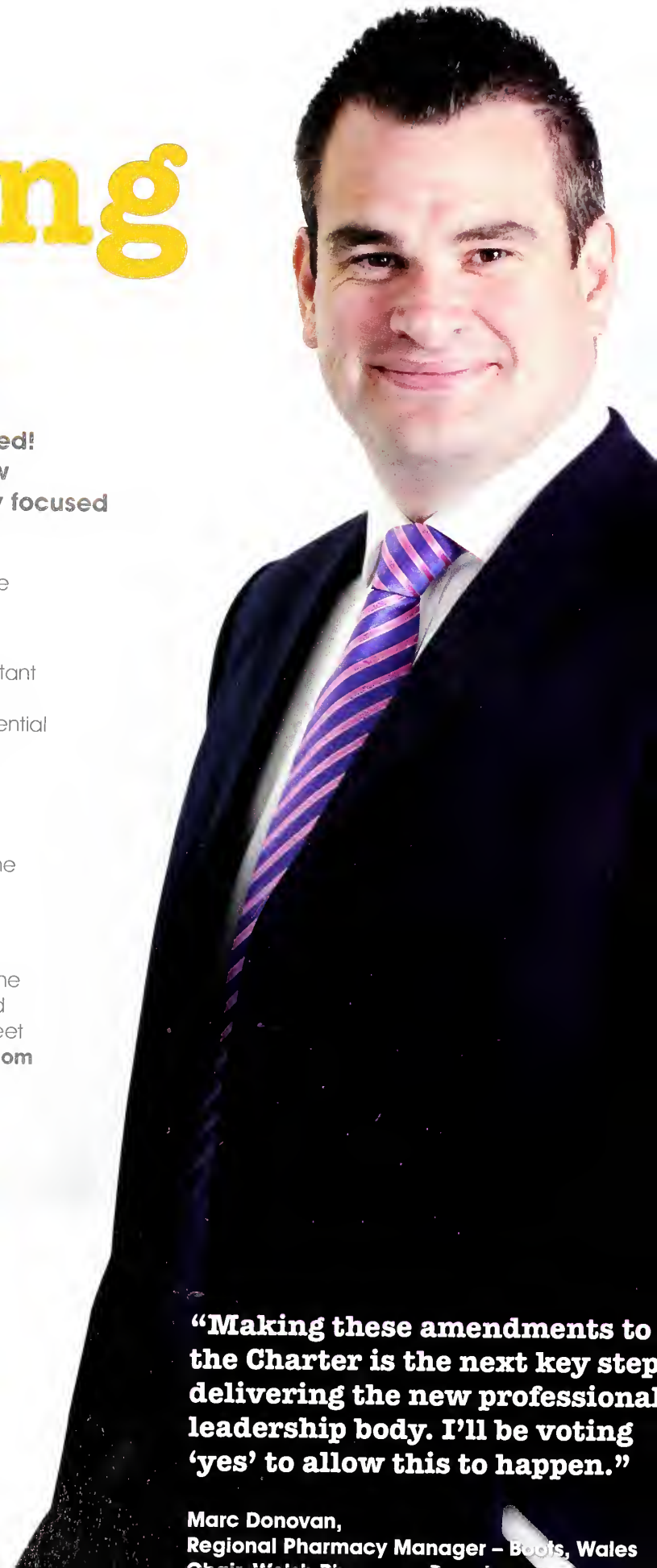

"Making these amendments to the Charter is the next key step delivering the new professional leadership body. I'll be voting 'yes' to allow this to happen."

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